"This book is, without a doubt, a gem of a resource for our communities' selfless servants."

–DR. TRACY S. HEJMANOWSKI
Licensed Clinical Psychologist; Founder, First Responder Project

HELPING THE HELPERS

The Clinicians Guide to First Responder Mental Wellness

Lt. David Dachinger (Ret.)
Bonnie Rumilly, LCSW/EMT
Dr. Stacy Raymond, PsyD

co-hosts of the Responder Resilience podcast

PRAISE FOR HELPING THE HELPERS

Individually and collectively, the authors have provided an invaluable contribution to the health and wellness of Emergency Responders through their podcasts and now through their gold nuggets for mental health professionals. This book taps the collective expertise of David, Bonnie, and Stacy along with their interviews with experts from all corners of this profession. The astute mental health professional who needs an introduction or a review of the fundamental skills of working with the heroes in this LEO and Emergency Responder profession will benefit from reading this book.

—Robbie Adler-Tapia, Ph.D., Psychologist
Author: *One Badge - One Brain - One Life*: *Preventative Maintenance for the Brain in the Line of Duty*

Helping the Helpers is a comprehensive resource for all clinicians who work with first responders. This Clinician's Guide offers a broad range of experience and insights in an easily digestible format, providing practical, no-nonsense guidance to support this unique and highly specialized population.

—Medina Baumgart, Psy.D., ABPP
Law Enforcement Agency-Embedded Psychologist
Board-Certified Specialist in Police and Public Safety Psychology

Helping the Helpers is a long-overdue and essential resource for first responders and their families. As a retired law enforcement officer with 30 years of service, I wish a resource like this had been available to me, as it offers valuable guidance for navigating the emotional challenges of retirement.

— Ernie Stevens, Retired Police Officer
Main Subject of Award-winning Documentary,
Ernie and Joe: Crisis Cops
Author and Speaker

This is the book I wish I had when I began researching organizational wellness programs and mental health resources for first responders over a decade ago. The authors leave no stone unturned in building cultural competence for clinicians working with the first responder population. In fact, it will be the first resource I share with our incoming therapy interns. By synthesizing rich content from their podcast guests with best practices for this unique population, the book offers a comprehensive and engaging read. While primarily aimed at clinicians, I highly recommend this book to anyone interested in exploring a wide range of wellness tools and resources to support first responders—whether you are a wellness coordinator, agency leader, spouse, or responder yourself.

—Wendy Hummell
Retired Detective
Health and Wellness Manager, Sedgwick County Sheriff's Office
Clinician in Training

Working as an embedded clinician across numerous first responder agencies, I cannot recommend this sentinel work strongly enough. More so, I encourage the inclusion of this book for the professional development of command staff and HR/Risk, for the awareness among unions and fraternal organizations, for the continued education of peer support teams, and for all nonprofits and clinicians who strive to serve first responders with greatest competency. This book is, without a doubt, a gem of a resource for our communities' selfless servants.

—Dr. Tracy S. Hejmanowski
Licensed Clinical Psychologist
Founder, First Responder Project

Helping the Helpers is a comprehensive guide for mental health clinicians seeking to support first responders through trauma-informed, culture-specific care. This must-read offers profound insights into the unique challenges faced by firefighters, law enforcement, EMS, and

dispatchers, along with practical tools to address issues like PTSD, moral injury, and chronic stress.

—Bryony Gilbey,
Director/Producer, *Honorable but Broken: EMS in Crisis*

Helping the Helpers is an essential field guide that bridges clinical expertise with the unique needs of First Responders, offering both clinical insight and real-world perspective. One particularly compelling chapter explores Suicide Psychological Autopsies, a structured process that reconstructs the mental and emotional state of a person who died by suicide. Through interviews with those who knew the deceased best, it reveals overlooked behaviors and warning signs that only become clear in hindsight. This retrospective analysis helps clinicians understand not just why someone died, but how similar tragedies might be prevented. By shifting the question from "What happened?" to "What could have happened differently?" the chapter offers a powerful framework for early detection and timely intervention.

—Barbara Rubel
Author, *But I Didn't Say Goodbye: Helping Families After a Suicide*, and *Living Blue: Helping Law Enforcement Officers and Their Families Survive and Thrive From Recruitment to Retirement*

Thank you David, Bonnie and Stacy. All I can say is Wow, what a service you have provided within the pages of this book. I love how you have identified the various types of first responders and the specific challenges each face. More importantly you have suggested methods to approach their treatment. It's never been a one size fits all and you have actually given tangible tools to those willing to help to do their jobs more effectively. Well done!

—John Kelly
Retired Law Enforcement
Law Enforcement Life Coach
Author, Motivational Speaker

Helping the Helpers is not just stories of First Responders, but a mirror held up to those who have ever buried their pain for the sake of duty. It delivers deeply personal accounts of what it means to serve from the shadows, and the invisible wounds that come with it. Essential reading for clinicians, law enforcement, and families, it explores trauma while providing a path toward healing, accountability, and post-traumatic growth. Powerful, honest, and profoundly necessary.

—Giovanni Rocco
Retired Law Enforcement
Covert FBI Deep Cover Operative
First Responder Mental/Behavioral Health Support Specialist
Author, *Giovanni's Ring*

This book is a fantastic tool for any therapist wishing to work with public safety personnel, addressing the vital need for understanding the unique experiences, stressors, and challenges First Responders face. It offers valuable insights to establish a safe environment that fosters validation, connection, understanding, and support—making it a must-read for clinicians in this field.

—Daniel Sundahl
Retired Paramedic/Firefighter
Counselling Therapist at DanSun Health

If you are a mental health professional looking to work with first responders through various therapeutic modalities, this book is a must read! This book allows clinicians to understand and provide a culturally responsive care approach with first responders, and provides an understanding of the needs and concerns that first responders have prior to therapy. It also offers valuable insights to help clinicians build rapport, leading to more successful outcomes for both the clinician and the first responder. Get a copy today, you won't be disappointed!!!

—Elizabeth Pol, M.A.
Founder-Resilient Heroes, NFP
Chicago Police Officer

As a therapist and spouse of a retired firefighter/EMT, I highly recommend this book. It offers valuable insights on how families can become allies rather than adversaries, addressing the challenges faced from rookie to retirement. A must-read for anyone wanting to foster understanding and support in first responder families.

—Tamara J. Green, LCSW
Love and Relationship Expert

HELPING THE HELPERS

THE CLINICIAN'S GUIDE TO FIRST RESPONDER MENTAL WELLNESS

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We proudly dedicate this book to the countless First Responders—the Rescue Warriors—who selflessly wear the uniform with honor and commitment, responding dependably 24/7, 365 days a year. These brave individuals exemplify selflessness, often placing their own safety and brain health at risk to aid others in their most desperate moments. While these remarkable individuals excel in their mission to care for others, they frequently struggle to care for themselves.

We also dedicate this book to the ever-growing community of compassionate clinicians, chaplains, peer supporters, and leaders who have dedicated themselves to helping Responders serving on the front lines of emergency services by providing healing, resilience, and a path toward post-traumatic growth.

A 911 CALL FOR MENTAL HEALTH

There are few greater honors in clinical work than being invited into the inner world of a First Responder. To sit across from someone who has witnessed the last breath of a stranger, or who has stood between chaos and order with quiet determination, is to enter sacred space. This is not casual work. It is not surface-level care. It is an agreement to witness what few others will ever see.

For many Responders, the therapy room is the one place where they can lay down their armor. The uniform may be off, but the imprint remains—etched into body and mind by years of hypervigilance, long shifts, and calls that don't end when the radio goes silent. When a Responder walks into the Clinician's office, it may be the first time they allow themselves to speak truths they've kept buried under duty and discipline.

And when they do—when they speak of the partner they couldn't save, the child they still dream about, or the moment they considered ending their pain—they are not just telling a story. They are extending trust. They are saying, *I am letting you see the part of me I don't show anyone else.*

That moment is not to be taken lightly. The Clinician's role here is not to fix, judge, or perform. It is to hold. To listen. To bear witness with humility and reverence. This work begins not with a treatment plan, but with presence. The kind of presence that says, *You don't have to explain everything. I'm here. I understand more than you think.*

This chapter—and this book—begins with a simple but profound threshold. If you are here to work with Responders, you must ask yourself, *Am I ready to be trusted with what others cannot carry?* Because once that door opens, once someone chooses to share what they've held in silence, the room becomes a sanctuary. And the work becomes a responsibility unlike any other.

HOLDING SPACE WITHOUT JUDGMENT

One of the most powerful roles a Clinician can play in a Responder's life is simply to bear witness. That may sound passive or even gentle, but in truth, it is a radical act. To bear witness is to hold space for the unspeakable. To stay present without flinching. To receive a story without needing to soften it, solve it, or explain it away.

When a First Responder finally speaks about a traumatic call, a failed rescue, a colleague's suicide, or the quiet unraveling of their sense of purpose, they are doing so after years—sometimes decades—of emotional suppression. These are not casual disclosures. They are confessions from the front lines, often never before expressed. The Clinician, then, becomes the sole custodian of these memories, trusted not only with confidentiality but with care.

The work isn't about probing for details or analyzing responses. It's about meeting the client with enough humanity to say, *I hear you. I'm here with you. And I'm not going anywhere.*

In a culture where emotional stoicism is equated with strength, just being seen can be a deeply healing experience. Responders often don't need dramatic interventions. Sometimes all they need is permission. Permission to be angry. To be scared. To be exhausted. To grieve what they've lost, even if what they've lost isn't tangible.

Validation, in this context, becomes a lifeline. It signals that what they're feeling is real. That it makes sense. That they are not broken; they are human. And that, perhaps for the first time, they don't have to carry it alone.

But this kind of witnessing comes with responsibility. It requires Clinicians to manage their reactions, to resist the urge to fix, and to understand that silence can be just as powerful as words. It demands presence, patience, and a steady emotional hand. It is not glamorous work. It is not easy work. But it is essential.

BEYOND CLINICAL COMPETENCE

First Responders live in a world that outsiders rarely glimpse, much less understand. Their days are structured around emergencies, their

language peppered with shorthand and dark humor, their bonds forged through shared danger. For a Clinician to be effective in this space, clinical training alone isn't enough. Cultural competence isn't a nice-to-have; it's the foundation of trust.

Trust, in this context, is earned not just by how you listen, but by what you already understand. Do you know what it means to work 24s, to put a rush on the bus, to sleep in a bunk room, to clear a difficult call only to respond to another minutes later? Do you grasp the tightrope Responders walk between public expectation and private reality? Can you appreciate the pride that comes with the badge, as well as the identity crisis that can unfold when that badge starts to feel heavy?

This isn't about memorizing jargon or romanticizing heroism. It's about respecting the culture deeply enough not to pathologize it. A Responder who's sarcastic or emotionally flat in session may not be disengaged; they may be surviving. Humor might be a shield. Silence might be a signal. It takes time, sensitivity, and situational fluency to tell the difference.

Missteps, however well-intentioned, can fracture the delicate bond between Clinician and Responder. Making assumptions about what a Responder "should" feel after a call, overemphasizing their trauma, or offering overly general platitudes can shut down dialogue. What appears to be compassion from a therapist's perspective may be perceived as condescension or naiveté by the client.

When Clinicians do take the time to truly understand Responder culture, it shows. And when it shows, it resonates. It allows the therapeutic space to feel less like a foreign environment and more like a place of belonging—a rare experience for someone whose professional identity often requires emotional isolation.

In this way, cultural understanding becomes a form of clinical precision. It's what allows the therapist to speak not just to the person, but to the world they inhabit. And in doing so, it opens the door for authentic connection.

YOU ARE NOT THE RESCUER

In the presence of profound suffering, the instinct to help can become an urge to rescue. Clinicians, especially those driven by empathy and a strong sense of purpose, may feel an inner pull to "save" the Responder sitting across from them. But this is not the work. First Responders do not need rescuing. They need someone who can sit with them steadily, respectfully, and without taking over.

Responders are accustomed to being in control. When they enter therapy, it is often with reluctance, shame, and fear that they might break a Clinician who can't handle the subject matter.

Therapists who rush to offer solutions or overlay their agenda onto the session can unintentionally reinforce the very stigma that keeps Responders from seeking help in the first place. It takes humility to withhold intervention, to recognize that presence and partnership often matter more than clinical fireworks.

There's a difference between being helpful and being heroic. The Clinician's role is not to diagnose and deliver answers, but to collaborate, witness, and empower. It's about letting the client lead, even when the path is winding. It's about trusting the process, even when the room goes quiet. It's about resisting the need to earn your place by over-performing.

This is especially true with Responders, who can often detect inauthenticity with unerring accuracy. They are trained to read people quickly and accurately; it's a matter of safety on the job. If a Clinician presents with even a hint of pretense, performative empathy, or overcompensation, it can create an immediate barrier to trust.

What builds trust instead is curiosity. Respect. A willingness to say, *I don't know what that's like, but help me understand*. That simple act of humility does more to foster connection than any scripted intervention ever could.

To do this work well is not to be the hero. It is to be the ally. The grounded, compassionate witness who holds the space, not fills it.

THE TOLL AND THE GIFT

Bearing witness to the pain of others has a cost. Clinicians who work with First Responders are exposed, secondhand, to some of the most harrowing moments a person can experience. The stories are raw. The emotions are intense. The weight of what is shared can settle into the therapist's nervous system, quietly accumulating if left unexamined.

The name for this is vicarious trauma. And it is not a sign of weakness. It is a natural byproduct of proximity to suffering. Over time, even the most grounded Clinician can feel the strain through fatigue, emotional numbness, irritability, or a creeping sense of futility. The risk isn't just burnout. It's a loss of the very qualities that make this work possible: empathy, presence, hope.

Acknowledging this toll is not a failure. It's a responsibility. Clinicians must take their wellness seriously, not as a form of self-indulgence, but as an ethical imperative. The work demands it. First Responders cannot afford to sit across from someone emotionally unavailable, checked out, or overwhelmed. They deserve a Clinician who is not just trained, but resourced.

Yet amid this heaviness, there is also extraordinary meaning.

To sit with a Responder in their most unguarded moments is a privilege few will ever know. It is a rare kind of trust, given sparingly and with great care. When that trust is honored—when a client begins to heal, to reconnect, to breathe more freely—the Clinician bears witness not just to pain, but to resilience.

Sometimes, the victories are quiet. A firefighter who stops drinking alone after shift. A dispatcher who no longer wakes in panic. A police officer who starts to believe that therapy isn't weakness. These moments may not make headlines, but they matter. Deeply.

There is a gift in this work: the gift of seeing people come home to themselves.

It is not an easy gift to carry. But for those who are called to it, the weight is matched by purpose. And the cost, though real, is part of the sacred exchange.

AN INVITATION TO REFLECT

There's a moment before the work begins when the Clinician must pause to examine their readiness. To ask not just *Can I do this? Should I? Am I called to this? Am I ready to carry what may be asked of me?*

Working with First Responders isn't just a specialty. It's a responsibility. It demands more than credentials or clinical skill. It asks for presence. For reverence. For a willingness to sit in the dark without flinching, to hear what has been unsaid, and to honor it without turning away.

This is the threshold.

On the other side lies the work: powerful, humbling, often heavy, always human. But before you step through, take this moment. Ask yourself:

- Am I prepared to hold space without needing to fix?
- Can I respect this culture without trying to reshape it?
- Will I care for myself with the same diligence I offer to others?
- Do I understand that this is sacred work, not because of what I bring to it, but because of what I'm being trusted with?

Not everyone is meant to walk this path. And that's okay. But for those who feel the call—for those who read these words and feel not just curiosity, but conviction—know this:

By the time a First Responder sits across from you, they've likely exhausted every internal resource they have. This isn't a routine appointment; it's their 911 call. You won't hear sirens, but the urgency is real. If you choose to take that call, understand what it means: to show up, to stay steady, and to carry the weight of someone who's spent a career doing the same for others.

This is where the work begins.

PART I

The Responder Mindset

1

THE BOX WE'RE TOLD TO LIVE IN

John Monaghan, a retired police chief, a veteran of rural patrols, union grievances, and too many fatal scenes to count, was no stranger to stress. He had built a career shouldering the chaos others couldn't, then suiting up again the next day to do it all over again. But this was different.

"I feel like I'm sliding my man card across the table to you," he told his therapist.

He said it only half in jest. In that moment, John was acknowledging something unspoken but deeply ingrained: that asking for help felt like handing over his sense of identity. To need help meant he had failed. Not the system, not the culture, but he, as a man, as a human, as a cop, had failed.

What the therapist said in response would stay with him. "You did the most courageous thing you could. You asked for help when you needed it."

That marked the start of John's healing, and it also exposed the inner architecture of resistance so many First Responders carry. The invisible walls. The emotional armor. The unspoken rules. What John would later come to call "the box."

For some First Responders, the decision to get help doesn't just challenge stigma. It threatens the very structure of how they see themselves. In the culture of service, protectors aren't supposed to falter. Fixers don't need fixing. Operators don't freeze. The strong ones aren't supposed to break.

And so, many don't ask for help. And if they do, it is often only when the weight has become too much to bear.

This is a chapter about those invisible walls. About what keeps Responders from speaking up. About the cultural traps Clinicians must learn to recognize.

Because courage doesn't always look like running toward gunfire. Sometimes it looks like walking into a therapist's office, whispering, *I think I'm not okay*, and finally letting the weight go.

THE CULTURAL BLUEPRINT OF SILENCE

John grew up under the shadow of silence. His father, a Vietnam veteran, never spoke about the war. Not once. He didn't cry. He didn't share. What he did express was a biting sense of humor and, when pushed too far, a terrifying temper.

That, John later realized, was the first box he ever lived in. It came with a set of invisible rules passed down through families, peers, media, and culture. Be tough. Don't show fear. Never ask for help. You can be angry, but never sad. Never ashamed. Never weak.

For First Responders, there's another layer to that box, which fits neatly inside the first. Be even tougher. Stay in control. You're the one people call when they're falling apart, so you don't get to fall apart. Emotional expression, especially vulnerability, is a liability. You deal with it. Quietly.

John remembers feeling like something was wrong with him. He didn't quite fit the mold, at least, not comfortably. However, that mold shaped him, and in many ways, served him well. It made him capable. Functional. Unshakable, at least on the surface.

In that structure, one emotion was always permissible: anger. Righteous, explosive, driving anger. Anger felt powerful. It felt safe. Sadness didn't. Grief didn't. Shame certainly didn't.

This blueprint is essential to understand. First Responders aren't resistant to help because they're unreachable. They're resistant because they've been conditioned, often from childhood, to equate vulnerability with failure. They've learned, implicitly and explicitly, that emotional control is the price of competence.

The blueprint works—until it doesn't.

Eventually, the box becomes too small. The walls don't hold. The weight of silence, accumulated over years of traumatic calls, broken shifts, moral injuries, and personal loss, grows heavier than the armor can carry.

THE PARADOX OF THE HELPER ROLE

It's a contradiction at the heart of the First Responder psyche: the people most trained and trusted to help others are often the least willing to accept help themselves.

John lived this paradox. As a police chief, he was the one others turned to for answers, for backup, for calm in the storm. And he delivered. From fatal accidents to town meetings, he wore the uniform of stability. Even when he was helping close friends through crises—officers battling PTSD, peers buckling under pressure—he kept his own struggles tucked away.

"I wanted to be the strong one," he admits. "Even with my closest friends."

This dynamic is deeply embedded in the culture. Helping earns respect. Needing help feels like failure. First Responders become fluent in the language of support—for others—but emotionally mute when it comes to their own needs.

The peer structure enforces the paradox. Trust and loyalty are hard-won and tightly guarded. There's an unspoken code: *Don't burden the team. Don't break the rhythm. Don't show your hand.* To disclose a personal struggle is to risk not just judgment, but exclusion. It threatens the belonging that many Responders rely on as a source of identity and meaning.

This isn't about pride in the traditional sense. It's about role identity. If your worth is wrapped in being the steady one, the strong one, the one others lean on, but what happens when you're the one who leans?

Clinicians working with this population often encounter this wall. A Responder might show up for an appointment and still insist they're fine. They may talk around the issue, shift into humor or stoicism,

or deflect with frustration. Because receiving help feels like betraying the very role that defines them. And some Responders are 100% convinced the job has not impacted them, and they have no trauma. We must be respectful of this and address it gently.

Understanding this paradox is key to building trust. It's not enough to offer support. The Clinician must make it safe for the Responder to stop performing strength. To allow them, perhaps for the first time, to be on the receiving end, and still be seen as whole.

BARRIERS THAT KEEP THEM FROM REACHING OUT

John didn't ask for help until he was ready to walk away from it all. Twenty-plus years in the job, and he was crashing. From the accumulation, the slow grind of trauma, responsibility, and silence. "It's like you're slowly adding pebbles to a backpack," he said. "Eventually, it weighs a ton."

He had seen the signs in others. He'd even coached officers through them. But when it came time to look in the mirror, the barriers that keep so many Responders from reaching out loomed large.

FEAR OF CONSEQUENCES

The fear isn't only personal. It's also professional. *What if I lose my job? What if my weapon is taken away? What if I'm declared unfit for duty?*

These concerns are often well-founded. Many Responders have seen peers sidelined, scrutinized, or labeled after seeking help. For leaders like John, the stakes are even higher: visibility, reputation, and command credibility. Asking for help feels like career suicide.

DISTRUST OF OUTSIDERS

Another barrier is cultural mistrust. First Responders often view Clinicians as civilians, outsiders to the world they live in. Some have tried therapy only to feel misunderstood, judged, or even shamed for the very coping mechanisms that keep them afloat.

THE MYTH OF THE BROKEN RESPONDER

Beneath all this lies a deeper myth, one that's quietly devastating: *If I admit I'm struggling, I must be broken.*

This myth is so powerful because it's binary. You're either fit or unfit. Strong or weak. Hero or liability. It leaves no room for complexity or growth.

What kept John from reaching out wasn't ignorance. It was fear. Fear of being seen differently by peers, of losing his role, of confronting his vulnerability. And yet, when he finally said, "I need help," something shifted. The world didn't fall apart. It opened.

Clinicians can't tear down these barriers overnight. But by understanding them, they can help First Responders move past fear and into the possibility of healing.

BREAKING THE BOX

When John set out to help his friend Jamey, a fellow officer diagnosed with PTSD, he wasn't thinking about changing the system. He was just trying to be there for someone he cared about. What he didn't realize at the time was that helping Jamey would open a door for his own healing, too. That was the beginning of breaking free of the box.

SAFE SPACES

Clinicians often ask, "How do we reach First Responders who resist traditional help?" The answer isn't persuasion. It's safety. Start with where they're willing to be. Use formats that feel familiar. Introduce stories that reflect their own without demanding immediate disclosure.

John emphasizes this too. Vulnerability, he says, can't happen just anywhere. "You don't want to walk into the locker room at your beer league hockey game and be like, 'Hey guys, I have some stuff I want to share.'" The space has to be right. The audience has to be safe.

REFRAMING VULNERABILITY AS STRENGTH

John often references the work of Brené Brown when teaching about emotional courage. In one story, Brown recalls speaking to a group of military special operators who were skeptical of her message. Vulnerability? That's not for warriors.

Until she asked: "When you run across a field of fire to rescue a buddy, are you exposed?"

"Yes."

"Does that make you vulnerable?"

"Yes."

"Does it take courage?"

"Yes."

The room got quiet. The connection clicked.

John uses this story because it reframes vulnerability in a way that makes sense within the culture of First Responders. It doesn't strip away toughness. It expands it. Emotional honesty becomes another kind of bravery, not separate from their identity, but woven into it.

THE PEER EFFECT

One of the most effective tools in breaking through is peer modeling.

Today, John co-teaches a mental health class at the Roger Williams Command Leadership School. He and his co-instructor, Doug, bring their lived experiences into the room and, through them, offer not just information, but also permission. They speak from inside the culture, which gives them instant credibility with those who are still guarded.

That's a powerful tool for Clinicians, too: align with peer voices. Use trusted messengers. Invite those who've done the work to help others take the first step.

2

INSIDE THE CULTURE

First Responders operate under a cultural code that is largely unspoken. It's not written in manuals or Standard Operating Procedures. You won't find it in policy binders or department memos. But it's everywhere: in the banter between calls, the silence after a tough one, the beer offered in place of a conversation, and the hard stare that says, "Don't ask."

We've heard this referred to by Responders as "the box" (see the previous chapter). There's the man box, passed down through generations of stoic fathers and military veterans, and inside it, the cop box (replace "cop" with any other type of First Responder), even smaller, even more rigid. It's a place where emotions are restrained, vulnerability is suspect, and pain is packed away for later—if later ever comes.

For many Responders, this cultural framework begins forming long before their first shift. They are drawn to the profession not just due to a desire to help, but by a deeper need to prove something—to themselves, to their parents, to a world that once taught them "big boys and girls don't cry." In this way, the job doesn't just shape them; it validates a story they've already been living.

But this invisible code comes with a cost. Over years, it compresses the human being inside the uniform, narrowing the acceptable range of emotion until only anger, sarcasm, or stoic silence remain.

Clinicians working with First Responders must first understand this: when someone walks into your office, they are stepping outside the code.

THE CULTURE OF TOUGHNESS

In First Responder culture, toughness and strength are not just assets; they're an identity. It's expected. It's admired. And at times, it's weaponized.

One of the police officers we interviewed on this topic recalled an early moment in his career. He had just responded to a traumatic call, something raw and disturbing. Looking for guidance, he turned to a supervisor and asked, "How do you deal with this kind of thing?" The response was quick and casual, "Have a beer."

This isn't just bad advice; it's sometimes indoctrinated into our Responders by the culture. A not-so-subtle reinforcement of the idea that real Responders don't talk, they cope. Alone. Preferably with alcohol. The underlying message is simple: Feelings make you fragile, and fragility gets people hurt.

The "suck it up" mentality isn't limited to words. It's modeled in behavior and enforced by silence. Recruits are rarely taught what to do with grief or guilt, but they learn fast what *not* to do: don't cry, don't flinch, don't falter. Most importantly, don't let anyone see the cost. One officer admitted he reached a point where he no longer cared whether he lived or died on the job; he just wanted the pain to stop. Yet, he still wore the mask. Still, he told supervisors he was "doing great."

Another officer described the emotional pressure as holding a beach ball underwater—relentless, exhausting. You can keep it down for a while, but eventually, it explodes to the surface. And when it does, it doesn't just affect the Responder. Families feel the fallout. Partners absorb the volatility. Entire lives can unravel before the mask finally comes off.

This toughness isn't just about image. It's about survival. Many Responders believe that if they let themselves feel everything, they'll lose the ability to function. So instead, they compartmentalize. They minimize. They bury it all in that box—and keep going. And as we know, First Responders are experts at compartmentalization on the job, but this skill also carries over into their personal lives.

Clinicians must understand that emotional suppression isn't a flaw. It's a cultural adaptation. When a client presents with detachment,

sarcasm, or even avoidance, it may not be resistance. It may be the only way they've ever known to stay upright.

GALLOWS HUMOR

If you want to understand how First Responders survive the unspeakable, listen to what they laugh at.

Gallows humor is part of the landscape—sharp-edged, irreverent, and often shocking to outsiders. It surfaces in the ambulance on the way back from a call, or back at the station after a cardiac arrest. For those on the inside, it's both acceptable and expected.

But like any coping tool, humor has a dark side. One officer admitted that the jokes eventually lost their sting and then ceased to be funny altogether. They had become a reflex, a way to distance themselves from pain, to dull what couldn't be acknowledged directly. The laughter wasn't about healing. It was about survival.

BROTHERHOOD AND BETRAYAL

First Responder culture is built on brotherhood (or sisterhood)—a tight-knit, unwavering bond forged in crisis. The kind of bond that means you can clear a building together, trade dark jokes over midnight coffee, and trust each other with your life. But in this culture, that same loyalty can turn cold fast when someone breaks the unwritten rules.

That's the paradox. Loyalty is sacred—until you show weakness. There's an unspoken expectation that you'll carry your pain quietly. That if you bleed, you do it out of sight. Peer support exists, yes, but sometimes in informal, fragile ways. When someone steps outside the cultural boundaries—seeks therapy, takes leave, admits they're not okay—they risk being seen as no longer reliable, no longer one of "us."

This isn't always overt. Sometimes it's subtle: the phone calls stop, the banter dries up, the sense of belonging fades.

Yet, peer support, when it emerges authentically, can be powerful. And this demonstrates the nature of peer dynamics as a double-edged

sword. Don't assume that Responders feel safe confiding in coworkers; many don't. And don't assume they're isolated either; many have found one or two trusted allies who help them hold it together.

POWER, RANK, AND EMOTIONAL REPRESSION

In the paramilitary structure of First Responder departments, hierarchy goes beyond a leadership structure to shape identity, order, and survival. The chain of command holds the organization together, but it also reinforces the unspoken rules of emotional conduct.

One officer described it with biting clarity: "If you saw any command staff, and they asked how you were doing, you said, 'Everything's great, sir.'" No matter what. No matter the trauma, the exhaustion, the unraveling happening underneath. To admit otherwise was to risk judgment, reputation, or worse—your job.

This kind of performative wellness is tactical. Many Responders believe, often with good reason, that acknowledging psychological strain might endanger their standing or be interpreted as a liability. Promotions, assignments, and even respect from colleagues can hang in the balance.

This fear isn't always unfounded. Many Responders we've talked to have felt pushed out—or believed they were being managed out—once they began to show signs of struggle. Even when the intent may have been supportive, the lack of trust in the system made any gesture feel suspect.

What results is a culture where vulnerability must be carefully calculated. Where those in pain may hide it most effectively in the moments they need help the most. And where "I'm fine" becomes both a shield and a prison.

Clinicians must understand the weight of institutional surveillance in these clients' lives. A Responder may want help, and still fear what your notes might mean. They may desperately need support, and still worry who will find out.

This sounds like paranoia, but it's a result of conditioning from years spent learning that trust can come with consequences.

To build a therapeutic relationship, Clinicians must convey confidentiality, neutrality, and safety. Until that foundation is solid, don't expect full disclosure.

IDENTITY AND HYPERVIGILANCE

Ask a First Responder who they are, and you're likely to hear their role before their name. "I'm a trooper." "I'm a firefighter." "I'm a medic." Not "I do this work," but "I am this work."

For many, that identity is not simply a job title; it's a worldview. The badge, the tattoo, the radio traffic, the readiness to jump into danger—these aren't just external symbols. They're internalized markers of meaning, purpose, and belonging. For many, it's the first place they've ever felt needed, trusted, or powerful.

But when the uniform becomes the self, what happens when the job ends or when the Responder breaks down?

The job fills the space that hobbies, relationships, or personal exploration might otherwise occupy. And it comes at a cost. Over time, Responders may lose sight of who they are outside the call. Their world narrows to shift schedules, radio codes, and incident reports. Life becomes a series of alerts, each one requiring full attention, total readiness, and absolute control.

This is hypervigilance, not just on the scene, but everywhere. One officer shared that even after retirement, simply driving through familiar streets in New Hampshire would trigger memories so intense he had to leave the state entirely. The trauma was in the geography. Every corner had a ghost.

Hypervigilance isn't always experienced as fear. Often, it's felt as a form of control. Sitting with your back to the wall. Scanning every room. Staying sharp, even off duty. Always on guard. For some, this feels like strength. For others, it becomes exhaustion.

Clinicians should recognize that hypervigilance is not simply a symptom; it's a skill that's been rewarded, reinforced, and embedded into identity. Unwinding it requires care. You're not asking the client to let their guard down. You're asking them to temporarily set aside the very tool that's kept them alive.

And when you begin to explore identity, tread gently. For a Responder in crisis, *Who am I if I'm not in uniform?* isn't rhetorical. It's destabilizing. Therapy, then, becomes not just about healing trauma, but about rebuilding a self.

A GROWING SHIFT TOWARD OPENNESS

While the traditional culture of stoicism and silence still runs deep, it is no longer the only story. Across departments, ranks, and generations, a shift is underway—one marked by courage not in concealment, but in openness.

More Responders are speaking their truth—publicly, boldly, and without shame. Chiefs are referring their members to Clinicians. Peer teams are becoming institutionalized. Embedded Clinicians are sitting at the table, not just showing up after the fact. And a new generation is stepping into the field with less resistance to therapy and more awareness of mental health.

This is the result of a growing body of education, advocacy, and lived experience. It's the ripple effect of Responders like the ones in this book, those who have chosen to say, *I went through it. I got help. And here's how I found my way out.*

It would be a mistake to see First Responder culture as monolithic or unchanging. Many are actively working to reshape it through podcasts, peer support, trauma-informed leadership, and their own personal example.

For Clinicians, this means that not every Responder who walks through your door will come armored and guarded. Some will come ready. Some will have the support of their department. And some may be there not just to recover, but to lead by example.